CHAPTER 10

REPORTING PERSONAL INJURIES AND ILLNESSES

HOW TO REPORT AND DOCUMENT OCCUPATIONAL INJURIES AND ILLNESSES

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CHAPTER 10

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HOW TO REPORT AND DOCUMENT OCCUPATIONAL INJURIES AND ILLNESSES

10.00 INTRODUCTION

This chapter explains the step-by-step procedures required to complete and process specific forms used to report and document occupational injuries and illnesses from first aid to emergency medical treatment at a medical facility.

See Chapter 9 - FIRST AID AND EMERGENCY MEDICAL TREATMENT which describes procedures for requesting first aid, first aid teams, and emergency transportation to a medical facility.

This chapter does not cover reporting serious occupational injury, illness, or fatality that are subject to special Cal-OSHA requirements. See Chapter 19 - SPECIAL REPORTING OF SERIOUS INJURY, ILLNESS, OR FATALITY, which describes the Departmental Reporting Protocol.

10.01 PURPOSE

The purpose of this chapter is to provide an explanation of the forms used to document occupational injuries or illnesses. The process includes documenting non-emergency medical care and arranging for emergency medical care at a clinic or hospital.

10.02 POLICY STATEMENT

Supervisors are responsible to report and document occupational injuries and illnesses, and arrange for appropriate workers' compensation benefits to employees who are injured or contract an illness arising out of their employment.

10.03 CALIFORNIA WORKERS' COMPENSATION PROGRAM

The California Workers' Compensation Program was established by the State Legislature to provide employees who incur an occupational injury or illness appropriate and reasonable medical care and indemnity payments (or their dependents in the event of an employee's work-related death) as necessary.

10.04 STATE COMPENSATION INSURANCE FUND (SCIF)

The State Compensation Insurance Fund (SCIF) is the State agency that acts as the Department's insurance adjusting agent in the administration of the Workers' Compensation Program. SCIF directs the worker's compensation claims process, medical contacts, medical payments, disability payments, and death benefits.

10.05 OVERVIEW OF CALTRANS WORKERS' COMPENSATION PROGRAM

The Caltrans Workers' Compensation Program is administered by the Office of Personnel Services, Workers' Compensation Case Management Unit in the Administrative Service Center, and by District Safety and Health Officers. The Case Manager or District Safety and Health staff person coordinates the claim with SCIF regarding medical contacts, medical payments, disability payments, and death benefits.

- Work-Related or Occupational Injury or illness

It is the goal of the Department to return an injured or ill employee to work as soon as medically possible following recuperation from the affects of a work-related injury or illness.

If it is determined that an employee will not be able to return to his/her normal duties as a result of a work-related injury or illness, a Workers' Compensation Case Manager and/or District Safety and Health staff will attempt to place the employee in another position, or if appropriate, a modified position.

- Non work-Related Injury or Illness

In order to accommodate employees who become disabled because of a non-work related injury or illness management can provide assistance to retain an employee through a process known as Reasonable Accommodation.

This program is used by employees who have a non work related disability. The affected employee must file a request for Reasonable Accommodation with his/her supervisor. For further guidance, consult the Caltrans Reasonable Accommodation Guide or contact the Office of Personnel Operations, Reasonable Accommodation Coordinator in the Administrative Service Center.

NOTE:

The State Compensation Insurance Fund (SCIF) and Cal-OSHA require specific reporting procedures to maintain records of occupational injuries and illnesses. To comply with these instructions, Caltrans management uses several forms to record the information.

The following describes the forms and the approximate sequence in which they are used to report and document occupational injuries and illnesses.

10.06 HOW TO USE Form PM-S-0066, "REPORT OF MINOR INJURY"

This is a Caltrans form. It is used to report ONLY minor occupational injuries or illnesses that do not require professional medical attention.

This form is not required if the injured and ill employee is taken to a medical facility for treatment. (See Section 10.08 for Form PM-S-0037.)

The Form PM-S-0066 is a small, green, 4 inch X 5-1/2 inch form.

A minor injury or illness is broadly defined as:

> AN INJURY OR ILLNESS THAT REQUIRES ONLY FIRST AID AND WOULD NOT REQUIRE THE ATTENTION OF A DOCTOR OR OTHER MEDICALLY TRAINED PERSON OR A VISIT TO A MEDICAL CLINIC.

First aid for minor cuts and bruises, removing a splinter, or other minor treatment that would be limited to the items found in State-approved first aid kits are normally classified as minor injuries.

Upon receiving information about a minor injury, or illness the supervisor shall do the following:

a. Give a Report of Minor Injury, Form (PM-S-0066), to the injured or ill employee to complete. (If the employee is unable to, the supervisor may fill out the form for the employee.)

b. The supervisor must sign the form.

c. The supervisor's signature is not an admission of liability; it simply means that the supervisor is aware of the incident/accident as reported by the employee.

NOTE:

The supervisor is responsible to review the circumstances surrounding the reported injury or illness and prepare a written report. See Chapter 4 - ACCIDENT INVESTIGATION AND ANALYSIS for more details.

Completing the Form PM-S-0066 ensures that the accident has been properly reported, documented, and the employee's benefits are protected.

1. The supervisor is required to send the completed REPORT OF MINOR INJURY, Form PM-S-0066, to:

   - the District Safety and Health Office for District employees
   - the Workers' Compensation Case Manager's Office for Headquarters-sourced employees.

2. The District Safety and Health Officers and Workers' Compensation Case Manager will file and retain copies of the Form PM-S-0066 for one (1) year.

SPECIAL NOTE No. 1:

It is important to understand that a minor injury and initial first aid treatment reported on a "Green Slip" (Form 66), may develop into a more serious medical problem in the future. Supervisors and employees should not assume that filing a "Green Slip" is the end of the reporting process.

SPECIAL NOTE No. 2:

If the injury/accident qualifies for an "exposure record", because of a toxic chemical exposure and falls under the Cal-OSHA regulations, the record must be maintained for 30 years. Contact the Safety and Health Office for more details.

A sample of Form PM-S-0066, REPORT OF MINOR INJURY, is included at the end of this chapter.

10.07 HOW TO USE Form "SCIF 3301"

"EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS"

This is a Department of Industrial Relations, Division of Workers' Compensation form used to report occupational injuries or illnesses.

The State Compensation Insurance Fund (SCIF) is the insurance adjusting agent for the State departments. Therefore, the form is referred to as "Form SCIF 3301." The form is 8-1/2 inches X 11 inches. The form is printed on four (4) pages of carbonized paper. Each page is clearly marked to identify how each page is processed. Page one is marked STATE FUND COPY, page two is marked EMPLOYER'S COPY, page three is marked EMPLOYEE'S COPY, and the last page is marked EMPLOYEE'S TEMPORARY RECEIPT.

Upon receiving information that an injury occurred or an employee has become ill, the supervisor shall:

a. Give the employee a copy of the Form SCIF 3301 within 24 hours of becoming aware of an injury or illness.

b. The employee shall complete the form as described in the written instructions.

c. Within **one working** day of the receipt of a completed Form 3301 from an employee, the supervisor shall complete his/her section of the form and give a dated copy to the employee.

d. The supervisor shall send the other copies to either the District Safety and Health Office, or the Workers' Compensation Case Manager immediately.

e. The District Safety and Health Office or the Workers' Compensation Case Manager is responsible to ensure that the form is completed and the information is processed in compliance with established procedures.

A sample of the Form SCIF 3301, EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS, is included at the end of this chapter.

10.08 HOW TO USE Form PM-S-0037

"**MEDICAL TREATMENT AUTHORIZATION**"

This form is used whenever an injured or ill employee is taken to a clinic or hospital for medical treatment by a physician or other medical professional.

Form PM-S-0037 is 8-1/2 inches X 11 inches. The original is sent to the Workers' Compensation Case Manager or to the District Safety and Health Office. One copy should be given to the treating physician or medical provider, and one copy for the supervisor.

Completed copies must be sent to:

- the District Safety and Health Office for District-sourced employees
- the Workers Compensation Case Manager Unit for Headquarters-sourced employees

The Medical Treatment Authorization form represents a financial authorization from Caltrans, and SCIF, to provide medical treatment to the employee and ensures that payment for services by the medical provider will be paid by the employer through SCIF.

- **When to use the MEDICAL TREATMENT AUTHORIZATION**

Whenever an employee is injured or becomes ill, the supervisor shall do the following:

1. Obtain a copy of the Form PM-S-0037 from the Safety and Health Office or Workers' Compensation Case Management Office.

2. Accompany the injured or ill employee to the medical provider and give a signed copy of the form to the medical provider.

   (The form provides information regarding the availability of modified work that may be necessary based upon the injury or illness and advice of the attending physician.)

3. Discuss the injuries with the attending physician in order to determine the affected employee's ability to return to work and perform a full range of duties.

The form must indicate any limitations placed upon the injured or ill employee and any necessary follow-up treatment or appointments, and must be signed by the attending physician before leaving the medical facility.

The form provides for the development of a MODIFIED WORK ASSIGNMENT AGREEMENT based on the physician's statement for the injured employee.

An example of the MEDICAL TREATMENT AUTHORIZATION, Form PM-S-0037, is included at the end of this chapter. The form may be modified to fit local needs.

* * * * * * * * *

10.09 HOW TO USE Form SCIF 3067

"EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS"

This is a State Compensation Insurance Fund (SCIF) form. This form must be filed with SCIF within five (5) working days (DO NOT DELAY SENDING THE FORM TO THE WORKERS' COMPENSATION CASE MANAGEMENT OFFICE OR TO THE DISTRICT SAFETY OFFICE) following an occupational injury or illness which:

1) results in lost time beyond the day of injury, or
2) requires professional medical treatment.

The front of the form provides space for specific information about the injury or illness. The reverse of the form provides for the supervisor's and manager's review. Both sides must be filled out completely by the supervisor.

Upon receiving information about an injury or illness, the first-line supervisor shall do the following:

a. Fill out an EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS.

b. Original form must be sent to:

- the District Safety and Health Office for District-sourced employees,
- the Workers Compensation Manager's Office for Headquarters-sourced employees.

Section 2581.4 of the State Administrative Manual (SAM) requires:

1. "**SOMEONE OTHER THAN AND SUPERIOR TO THE INJURED PERSON SHOULD FILL OUT THE FORM**."
2. "The form shall **NOT** be completed by the injured employee, and **UNDER NO CIRCUMSTANCES IS THE INJURED EMPLOYEE TO SIGN THE SCIF FORM 3067."**
3. "This form is state management's report of the incident to SCIF and is considered confidential."

The District Safety and Health Officer or the Workers' Compensation Case Manager is responsible to send the completed Form SCIF 3067 to the State Compensation Insurance Fund (SCIF).

A sample of the Form SCIF 3067, EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS, is included at the end of this chapter.

10.10 HOW TO USE Form STD. 634

"ABSENCE AND ADDITIONAL TIME WORKED REPORT"

The Form STD. 634 is used to record employee absences associated with occupational injuries or illnesses. The form is used in addition to electronic or written time reporting procedures. (See next page for details.)

Supervisors are responsible to give a copy of the form to an injured or ill employee whenever they are off work because of a work-related injury or illness.

The employee shall record all absences on the form for each pay period or portion thereof, attach copies of required medical documents, and submit the form to their supervisor for approval. All medical documents must be signed by a physician. If the employee is unable to complete the form, the supervisor shall complete the form and sign for the employee.

The supervisor is responsible to review the Form STD. 634, verify the employee was absent on the day(s) indicated or portions thereof, sign, and date the form. The supervisor sends the Form STD. 634 and the original medical documents to the Workers' Compensation Personnel Transaction Unit.

All records of time worked or time-off, electronic or written, must be submitted in the usual manner by the employee or supervisor to the attendance person and other appropriate person or location for handling and processing.

Unless otherwise directed, the time off associated with an occupational injury or illness is charged to the employee's leave credits; i.e., sick leave, vacation, annual leave, or other leave credit. (The employee receives full pay for the day of injury or illness and no charge is made for the absence.) If an employee has insufficient or no leave credits available to charge for the period of absence, the time off is reported as "dock" on the Form STD. 634.

Employees shall not charge any time off to Industrial Disability Leave (IDL) unless instructed to do so by the Personnel Transactions Workers' Compensation Unit.

The State Compensation Insurance Fund (SCIF) is responsible to verify and approve all claims for benefits related to an occupational injury or illness. Once the claim has been approved, SCIF may verify the employee's time off as Indus-trial Disability Leave (IDL), at which time the employee's previously used leave credits may be restored. The Personnel Transactions Workers' Compensation Unit will notify the employee, the supervisor, and others accordingly.

Time off associated with an occupational injury or illness must be reported on the Form STD. 634 as outlined below:

1. Electronic Time Reporting –

   - Maintenance employees reporting time through MERS, and
   - Staff employees reporting time through TRS:

   A Form STD. 634 is used in addition to electronic time reporting. Enter the symbol and number of hours in date blocks for each day or portion thereof, and draw a circle around the number. Write "Work-related injury or illness" and the claim number on the form.

2. Written Time Reporting –

   - Staff employees utilizing a Staff Time Sheet, Form FA-708:

   Employee must complete both Form FA-708 and Form STD. 634. The hours are entered on Form STD. 634 as described above. The same hours are also entered on the Form FA-708 and circled. Write "Work-related injury or illness" and the claim number on the form.

A sample of the Form STD. 634 is included at the end of this chapter.

10.11 HOW TO USE Form "PM-S-0067"

"DATA INPUT FOR PERSONAL INJURY ACCIDENT"

This is a Caltrans form used for the Safety Information Management System (SIMS) program. The Data Input Form PM-S-0067 is the last official document required in the sequence of events following the reporting of an occupational injury or illness.

The form must be filled out in order to ensure that an injury or illness has been properly documented and is included in the SIMS computer data base. The form is for internal Departmental use only.

The form **is filled out by the supervisor** and he/she sends it to:

- For **District employees**: the District Safety and Health Office.

  The District Safety and Health Office staff reviews and verifies the information and enters the data into SIMS.

- For **Headquarters-sourced employees**: the Workers' Compensation Case Management Office at the Administrative Service Center.

  The Workers' Compensation Case Management Office reviews the information and then forwards the form to the Headquarters Office of Safety and Health in the Administrative Service Center.

  The Headquarters Office of Safety and Health reviews and verifies the information and enters the data into SIMS.

The purpose of the "Data Input For Personal Injury Accident" form is:

a) To collect data that will identify the employee, the equipment, and detailed information describing the physical and environmental conditions surrounding the accident.

b) Based upon the information provided by the employee, and after completing an investigation, the first-line supervisor fills out the front of the form. All boxes describing physical and environmental conditions must be filled.

c) Supervisors are responsible to ensure that all of the data fields have been reviewed and all the information on the computer input document is complete and accurate. Call the District Safety and Health Office or Workers' Compensation Case Manager's Office if you need assistance.

NOTE:

Before the information is "keyed" into the SIMS data base, the Safety Office staff (District or Headquarters) reviews the supervisor's comments for completeness and accuracy. If the information is incomplete and/or there are errors, the original Form PM-S-0067 will be returned to the supervisor for correction and/or for additional information as may be indicated.

A sample of the DATA INPUT FOR PERSONAL INJURY ACCIDENT, Form PM-S-0067, is included at the end of this chapter.

10.12 HOW TO USE Form PM-S-0004

"MODIFIED WORK ASSIGNMENT AGREEMENT"

This form is used to document a formal written agreement between management and an injured or ill employee. The modified work assignment establishes a transition period in order to allow an employee to return to his/her position without loss of pay and benefits. It is also used to document the physical limitations established by a physician as the result of an occupational injury or illness.

Modified work is a temporary work assignment during the recuperation of an injured or ill employee. A modified work assignment allows an injured or ill employee the opportunity to return to work and perform special short-term projects/ assignments or limited tasks of usual and customary duties.

ALL MODIFIED WORK AGREEMENTS MUST HAVE WRITTEN MEDICAL SUBSTANTIATION ATTACHED TO THE AGREEMENT DOCUMENT.

The effective dates of the modified work assignment should not exceed ninety (**90**) calendar days. Extensions may be granted on a case by case basis after consultation with the Worker's Compensation Case Manager or the District Safety Officer as appropriate.

A MODIFIED WORK ASSIGNMENT AGREEMENT, Form PM-S-0004, lists the employee's name, job title, date of injury/illness, and effective dates of the modified work assignment.

Supervisors must ensure that the injured or ill employee has read, understands, and agrees to the provisions of the agreement before it can be approved.

- **When to use a "Modified Work Assignment Agreement"**

Supervisors shall make every effort to provide temporary modified work assignments for employees with occupational or non-occupational injuries or illnesses when their treating physician indicates:

1) That the employee is not able to perform the full range of duties for a specific transition period of time.

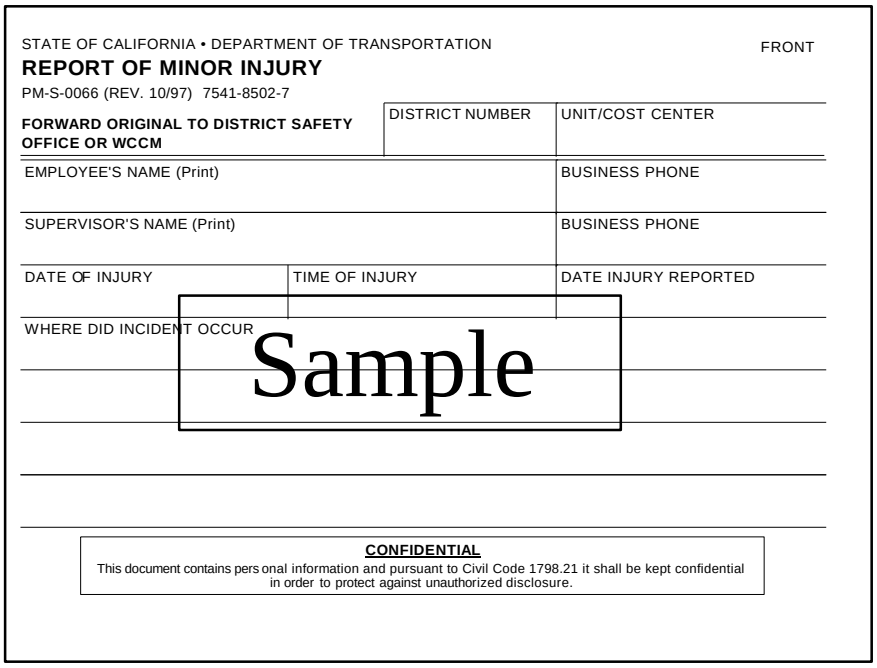
2) That the employee is able to perform a limited range of duties or other productive work during a specific transition period of time.

A sample MODIFIED WORK ASSIGNMENT AGREEMENT, Form PM-S-0004, is included at the end of this chapter.

REPORT OF MINOR INJURY

Form PM-S-0066

"THE GREEN SLIP"



STATE OF CALIFORNIA • DEPARTMENT OF TRANSPORTATION

FRONT

REPORT OF MINOR INJURY

PM-S-0066 (REV. 10/97) 7541-8502-7

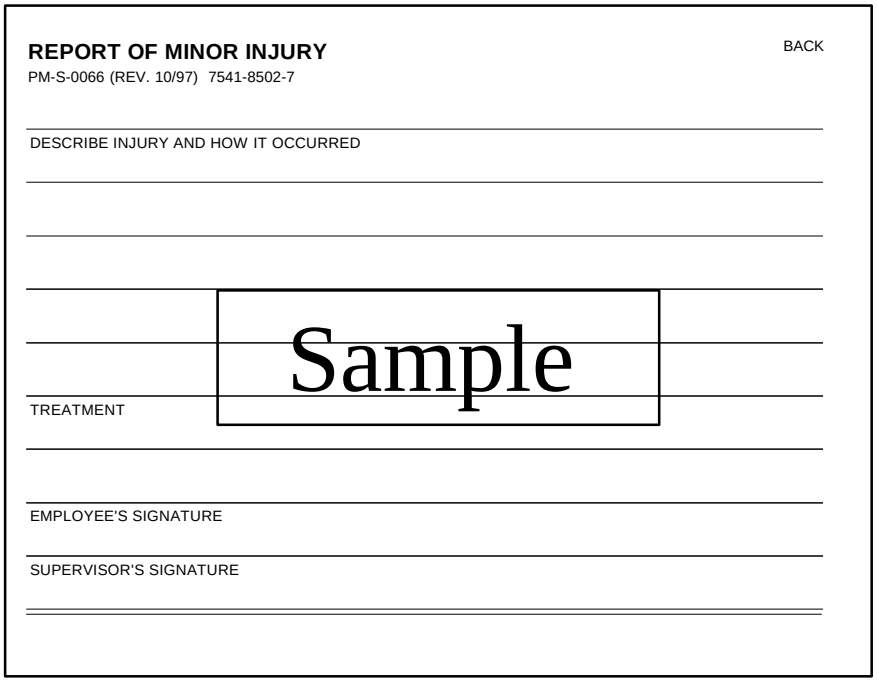
FORWARD ORIGINAL TO DISTRICT SAFETY OFFICE OR WCCM	DISTRICT NUMBER	UNIT/COST CENTER
EMPLOYEE'S NAME (Print)		BUSINESS PHONE
SUPERVISOR'S NAME (Print)		BUSINESS PHONE
DATE OF INJURY	TIME OF INJURY	DATE INJURY REPORTED

WHERE DID INCIDENT OCCUR

Sample

CONFIDENTIAL

This document contains personal information and pursuant to Civil Code 1798.21 it shall be kept confidential in order to protect against unauthorized disclosure.



REPORT OF MINOR INJURY

BACK

PM-S-0066 (REV. 10/97) 7541-8502-7

DESCRIBE INJURY AND HOW IT OCCURRED

Sample

TREATMENT

EMPLOYEE'S SIGNATURE

SUPERVISOR'S SIGNATURE

MEDICAL TREATMENT AUTHORIZATION

Form PM-S-0037

STATE OF CALIFORNIA • DEPARTMENT OF TRANSPORTATION

MEDICAL TREATMENT AUTHORIZATION

PM-S-0037 (REV 3/1997)

The supervisor will take the injured to the doctor for treatment.

ADJUSTING AGENT
STATE COMPENSATION INSURANCE FUND

CALTRANS USE ONLY
☐ First Aid ONLY, not reportable
☐ Injured Treatment report to Cal-OSHA

PERSONAL INFORMATION NOTICE

Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code Sections 1798, et seq.), notice is hereby given for the request of personal information by this form. The requested personal information is voluntary. The principal purpose of the voluntary information is to facilitate the processing of this form. The failure to provide all or any part of the requested information may delay processing of this form. No disclosure of personal information will be made unless permissible under Article 6, Section 1798.24 of the IPA of 1977. Each individual has the right upon request and proper identification, to inspect all personal information in any record maintained on the individual by an identifying particular. Direct any inquiries on information maintenance to your IPA Officer.

* EMPLOYEE'S NAME	UNIT	COST CENTER	BUSINESS PHONE
* SUPERVISOR'S NAME			BUSINESS PHONE
* AUTHORIZED SIGNATURE			DATE

TO ATTENDING PHYSICIAN:

The form represents authorization to treat the above employee for a work incurred injury or illness.

The Department of Transportation provides short-term, modified work assignments for employees' work-related injuries in order that time away from work may be kept to a minimum. Please consider the availability of this modified work before making a decision on our employee's estimated period of disability. Because of our varied work activities, usually some type of employment can be found to meet injured employee's medical limitations.

If you have any questions regarding modified work assignments, please contact Caltrans District Safety Office or your Worker's Comp. Case Manager.

Please complete the items on the form below and return with employee.

INJURY STATUS REPORT

TREATMENT ADMINISTERED

- ☐ Office visit injury treatment
- ☐ Redress
- ☐ Medication
- ☐ Physical therapy
- ☐ Physical exam (results will be transmitted by other means)
- ☐ If presently working, return before or after shift on: ____ / ____ / ____

WORK STATUS

- ☐ Return to regular work Date: _____
- ☐ Return to modified work _____ days
- ☐ Unable to return to work for duration of disability _____ days
- ☐ On schedule established by initial report _____
- ☐ Re-evaluation or comments: _____

MODIFIED WORK AS INDICATED BELOW

- ___ 1. No prolonged standing or walking
- ___ 2. No climbing, bending, or stooping
- ___ 3. Limited use of the right/left hand
- ___ 4. Right/Left handed work only
- ___ 5. No work near moving machinery during modified work _____
- ___ 6. No twisting motion
- ___ 7. Weight lifting restriction:
  - ___ 0 - 15 pounds
  - ___ 15 - 35 pounds
  - ___ 35 - 50 pounds

DOCTOR'S COMMENTS

DOCTOR'S NAME	BUSINESS ADDRESS
DOCTOR'S SIGNATURE	BUSINESS PHONE

Complete original and 2 copies, distribute as follows:

- Original to District Safety Officer or WCCM
- Copy to physician
- Copy to supervisor or injured/ill employee

NOTE: This form shall be given to the physician along with any explanation necessary.

**Fill in by supervisor*

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

Form SCIF 3301

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

If you are injured or become ill because of your job, you may be entitled to workers' compensation benefits.

Complete the **"Employee"** section and give the form to your employer. Keep the copy marked **"Employee's Temporary Receipt"** until you receive the dated copy from your employer. You may call the Division of Workers' Compensation at **1-800-736-7401** if you need help in filling out this form or in obtaining your benefits. An explanation of workers' compensation benefits is included on the back of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

PETICION DEL EMPLEADO PARA BENEFICIOS DE COMPENSACIÓN DEL TRABAJADOR

Si Ud. se ha lesionado o se ha enfermado a causa de su trabajo, Ud. tiene derecho a recibir beneficios de compensación al trabajador.

*Complete la sección **"Empleado"** y entregue la forma a su empleador. Quédese con la copia designada **"Recibo Temporal del Empleado"** hasta que Ud. reciba la copia fechada de su empleador. Si Ud. necesita ayuda para completar esta forma o para obtener sus beneficios, Ud. puede hablar con la Division de Compensación al Trabajador llamando al **1-800-736-7401.** En la parte de atrás de esta forma se encuentra una explicación de los beneficios de compensación al trabajador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee: ***Empleado:***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of injury. *Hora en que ocurrió* _____ a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
7. Social Security Number. *Número de Seguro Social del Empleado* _____
8. Signature of employee. *Firma del empleado.* _____

Employer - complete this section and give the employee a copy immediately as a receipt.
Empleador - complete esta sección y déle inmediatamente una copia al empleado como recibo.

9. Name of employer. *Nombre del empleador.* _____
10. Address. Dirección. _____
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañia de seguros o agencia administradora de seguros.* **STATE COMPENSATION INSURANCE FUND** _____
15. Insurance Policy Number. *El número de la póliza del Seguro.* _____
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* _____ 18. Date. *Fecha.* _____ 19. Telephone. *Telefono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

STATE COMPENSATION INSURANCE FUND

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañia de seguros. administrador de reclamos. o dependiente representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de **un dia hábil** desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

SCIF 3301 (REV. 6-95) - DWC Form 1 (REV. 1-94)

STATE FUND COPY

THIS FORM IS NOT SHOWN FULL SIZE.

EMPLOYERS' REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Form SCIF 3067

State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type, if possible). Mail original and one copy to:

STATE COMPENSATION INSURANCE FUND

Refer to STATE ADMINISTRATIVE MANUAL, SECTIONS 2581.2 – 2581.5 for instructions on completion and routing.

BOTH SIDES OF THIS FORM MUST BE COMPLETED

OSHA Case No. _____ ☐ Fatality

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

NOTICE: California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident ***OR*** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury/illness, or death must be reported **immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. DEPARTMENT | 1A. AGENCY CODE OR SCIF POLICY NUMBER | DO NOT USE THIS COLUMN
2. MAILING ADDRESS (Number and Street, City, ZIP) | 2A. PHONE NUMBER | Case No.
3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, ZIP) | 3A. DIV./LOCATION CODE | Ownership
4. NATURE OF BUSINESS Governmental Agency | 5. STATE UNEMPLOYMENT INSURANCE ACCT. NO. | Industry
6. TYPE OF EMPLOYER | Occupation

☐ PRIVATE ☒ STATE ☐ CITY ☐ COUNTY ☐ SCHOOL DIST. ☐ OTHER GOVERNMENT - SPECIFY _____

EMPLOYEE

7. EMPLOYEE NAME | CSID# | 8. SOCIAL SECURITY NUMBER | 9. DATE OF BIRTH (mm/dd/yy) | Sex
10. HOME ADDRESS (Number and Street, City, ZIP) | 10A. PHONE NUMBER | Age
11. SEX ☐ MALE ☐ FEMALE | 12. OCCUPATION (Regular job title–No initials, abbreviations or numbers) | CBID# | 13. DATE OF HIRE (mm/dd/yy) | Daily hours
14. EMPLOYEE USUALLY WORKS _____ hours per day _____ days per week _____ total weekly hours | 14A. EMPLOYMENT STATUS (See instructions in 14A continued below.) ____ regular full-time ____ part-time ____ temporary ____ seasonal | 14B. Under what class code of your policy were wages assigned? | Days per week
15. GROSS WAGES/SALARY $ _____ per _____ | 16. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging, overtime, bonuses, etc.)? ☐ YES, $ _____ per _____ ☐ NO | Weekly hours

INJURY OR ILLNESS

17. DATE OF INJURY OR ONSET OF ILLNESS (mm/dd/yy) | 18. MILITARY TIME INJURY/ILLNESS OCCURRED | 19. MILITARY TIME EMPLOYEE BEGAN WORK | 20. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy) | Weekly wage
21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ YES ☐ NO | 22. DATE LAST WORKED (mm/dd/yy) | 23. DATE RETURNED TO WORK (mm/dd/yy) | 24. IF STILL OFF WORK, CHECK THIS BOX ☐ | County
25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? ☐ YES ☐ NO | 26. SALARY BEING CONTINUED? ☐ YES ☐ NO | 27. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm/dd/yy) | 28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm/dd/yy) | Nature of injury
29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, tendonitis of left elbow, lead poisoning. | Part of body
30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City) | 30A. COUNTY | 30B. ON EMPLOYER'S PREMISES? ☐ YES ☐ NO | Source
31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop. | 32. OTHER WORKERS INJURED/ILL IN THIS EVENT? ☐ YES ☐ NO | Event
33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold. | Sec. Source
34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck. | Extent of Injury
35. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.

36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP) | 36A. PHONE NUMBER
37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP) | 37A. PHONE NUMBER
38. WAS ANOTHER PERSON RESPONSIBLE? ☐ YES ☐ NO | 39. PERS/STRS MEMBERS ☐ YES ☐ NO | 40. ARE LEAVE CREDITS AVAILABLE TO BE USED IN SUPPLEMENTING INDUSTRIAL DISABILITY LEAVE BENEFITS? ☐ YES ☐ NO

14A. EMPLOYMENT STATUS CONT. (Check current status of employment, not status at time of injury.)

____UNEMPLOYED ____ON STRIKE ____DISABLED ____RETIRED ____LAID OFF ____OTHER

Completed by (type or print)	Signature	Title	Date

SCIF 3067 (REV. 2-93) STATE

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY. A CLAIM FORM MUST BE GIVEN TO THE INJURED WORKER WITHIN ONE WORKING DAY OF YOUR KNOWLEDGE OF OCCUPATIONAL INJURY OR ILLNESS WHICH RESULTS IN LOST TIME OR MEDICAL TREATMENT.

THIS FORM IS NOT SHOWN FULL SIZE.

ABSENCE AND ADDITIONAL TIME WORKED REPORT

Form STD. 634

STATE OF CALIFORNIA
ABSENCE AND ADDITIONAL TIME WORKED REPORT
STD. 634 (REV.5-98)

PAY PERIOD — 1. MONTH — YEAR — SEMIMONTHLY STATUS ONLY — ☐ FIRST HALF ☐ SECOND HALF
TIME BASE — WWG — CB/ID
ALTERNATE WORKWEEK SCHEDULE ☐ 4/10/40 ☐ 9/8/80

2. NAME (First Middle Last) — 3. SOCIAL SECURITY NUMBER — 4. POSITION NUMBER

5. ABSENCE WITH PAY

(S) ☐ SICK LEAVE SELF
(SF) ☐ SICK LEAVE FAMILY ILLNESS
(SD) ☐ SICK LEAVE DEATH IN FAMILY (RELATIONSHIP) _____
(PL) ☐ PERSONAL LEAVE
(A/L) ☐ ANNUAL LEAVE
(V) ☐ VACATION

(B) ☐ BEREAVEMENT LEAVE
(TO) ☐ USING OVERTIME CREDITS
(TH) ☐ USING HOLIDAY CREDITS
(TE) ☐ USING EXCESS HOURS CREDIT
(PH) ☐ USING PERSONAL HOLIDAY
(SH) ☐ USING SATURDAY HOLIDAY
(E) ☐ PAID EDUCATIONAL LEAVE

(C) ☐ CATASTROPHIC LEAVE DONATIONS RECEIVED AND USED
(M) ☐ SHORT-TERM MILITARY LEAVE (Calendar Days) _____ (Attach Military Duty Orders)
(NDI) ☐ NONINDUSTRIAL INJURY
INDUSTRIAL ILLNESS OR INJURY (Report of Industrial Injury must be submitted)
(TD) ☐ TEMPORARY DISABILITY
(IDL) ☐ INDUSTRIAL DISABILITY LEAVE
(IDL/S) ☐ INDUSTRIAL DISABILITY LEAVE WITH SUPPLEMENTATION
OTHER _____

(J) ☐ JURY DUTY (Make copy for Accounting)
(SW) ☐ SUBPOENAED WITNESS ☐ PARTY ☐ EXPERT
COURT — CITY
☐ NO FEES RECEIVED ☐ FEES TO BE REMITTED TO STATE
☐ FEES RETAINED
CHARGE ABSENCE TO
☐ VAC ☐ CTO ☐ ABSENCE WITHOUT PAY

6. ABSENCE WITHOUT PAY

(L) ☐ INFORMAL LEAVE GRANTED (11 Working days or less)
(L) ☐ INFORMAL LEAVE GRANTED (15 Working days or less) (CSUC)
(A) ☐ ABSENCE WITHOUT LEAVE (AWOL) (19996.2 OR 19572)
☐ TEMPORARY LEAVE (30 Calendar days or less)
☐ ABSENCE WHILE ON PROBATION
(ML) ☐ MENTORING LEAVE
(FM) ☐ FAMILY AND MEDICAL LEAVE ACT (FMLA)

PAY PERIOD:
☐ QUALIFYING
☐ NONQUALIFYING

7. DATES OF ABSENCES AND EXTRA TIME WORKED
(Enter symbol and number of hours in date blocks. See reverse for legends and symbols not noted above. If the absence is for a compensable injury waiting period, add X to other symbol.)

REPORTING	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL
7A. HRLY INT/PY HRS TO BE PAID																																
7B. SICK																																
7C. BEREAVE-MENT																																
7D. VACATION																																
7E. A/L																																
7F. TO, TH, TE, FM PH, SH, E, M, SW, J, PL, ML																																
7G. L, A																																
7H. STRAIGHT TIME, WO, P, HC, WE																																
7I. PREMIUM TIME WO, P																																

8. REASON FOR ABSENCE OR EXTRA HOURS WORKED ☐ MEDICAL APPOINTMENT ☐ DENTAL APPOINTMENT

9. CERTIFICATE BY EMPLOYEE — *To the best of my knowledge and belief, the facts stated are accurate and in full compliance with legal requirements.* — EMPLOYEE SIGNATURE ▷ — DATE

10. RECOMMENDATION AND SUBSTANTIATION OF SUPERVISOR
☐ APPROVAL RECOMMENDED ☐ APPROVAL NOT RECOMMENDED
SUBSTANTIATION SHALL BE REQUIRED FOR SICK LEAVE OF MORE THAN TWO CONSECUTIVE WORK DAYS. SHOW METHOD OF VERIFICATION BELOW.
SIGNATURE OF SUPERVISOR ▷ — DATE

11. STATEMENT BY PHYSICIAN (Not to be completed by attending physician for industrial illness or injury.)
☐ DOCTOR STATEMENT ATTACHED
☐ AS PHYSICIAN, I EXAMINED AND TREATED OR PRESCRIBED FOR THIS PATIENT ON THESE DATES
DATE OF RETURN TO WORK — IF STILL DISABLED, GIVE ESTIMATED DATE OF RETURN TO WORK
THE ILLNESS OR INJURY CAUSING THE DISABILITY WAS
SIGNATURE OF ATTENDING PHYSICIAN ▷ — DATE

12. PERIOD ON DISABILITY COMPENSATION — FROM — TO

13. DISABILITY COMPENSATION SUPPLEMENT

HOURS	SICK LEAVE	VACATION	CTO	HOLIDAY CREDIT

14. OFFICIAL DEPARTMENTAL ACTION ☐ APPROVED_____ ☐ DISAPPROVED_____
REVIEWED BY

THIS FORM IS NOT SHOWN FULL SIZE.

DATA INPUT FOR PERSONAL INJURY ACCIDENT

Form PM-S-0067

STATE OF CALIFORNIA • DEPARTMENT OF TRANSPORTATION

DATA INPUT FOR PERSONAL INJURY ACCIDENT

PM-S-0067 (REV. 1/93)

Page 1 of 2 Front

CONFIDENTIAL

This document contains personal information and pursuant to Civil Code 1798.21 it shall be kept confidential in order to protect against unauthorized disclosure.

ACCIDENT INFORMATION (THIS FORM TO BE COMPLETED BY FIRST-LINE SUPERVISOR AND CHECKED BY THE SAFETY OFFICER)

DATE OF ACCIDENT	TIME (24 HOUR)	OTHER CALTRANS EMPLOYEE INJURED? ☐ YES ☐ NO CALTRANS VEHICLE(S) INVOLVED? ☐ YES ☐ NO	ACCIDENT NUMBER P -

ACCIDENT DESCRIPTION

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	M.I.	SEX	DATE OF HIRE

SOCIAL SECURITY NUMBER	BIRTH DATE	DRIVER'S LICENSE NUMBER	DRUG TEST (SENSITIVE POSITIONS ONLY) ☐ Yes ☐ No

CLASS-CODE	MAINTENANCE ACTIVITY NUMBER	EMPLOYMENT STATUS (CHECK ONE) ☐PFT ☐PI ☐LT ☐PPT ☐TAU ☐SPP ☐RA ☐SA ☐CE**

DISTRICT NUMBER	UNIT/COST CENTER*	LOST TIME (DAYS)	MODIFIED WORK (DAYS)	SCIF CLAIM NUMBER

DETAILED INFORMATION Circle the appropriate entry

A. TREATMENT STATUS
01 CAL-OSHA
02 FIRST AID
03 NOT CLEARLY JOB RELATED
04 EXPOSURE ONLY

B. FATAL IF YES, ENTER DATE OF DEATH
01 YES
02 NO _____

C. PERSONAL PROTECTIVE EQUIPMENT
01 YES
02 NO

D. PREVENTABILITY BY EMPLOYEE
01 YES
02 NO
03 INJURY CLEARLY THE FAULT OF ANOTHER CALTRANS EMPLOYEE
04 INJURY CLEARLY THE FAULT OF ANOTHER PARTY

IF 03 ENTER THE SSN OF THE CALTRANS EMPLOYEE:

__ __ __ __ __ __ __ __ __

E. LOCATION OF ACCIDENT
01 CAFETERIA/RESTAURANT
02 CITY STR EET
03 CONSTRUCTION SITE
04 CREW'S QUARTERS
05 ELEVATOR
06 EQUIPMENT BAY
07 FREEWAY/HIGHWAY
08 FREEWAY RAMP
09 FREEWAY LANE CLOSURE
10 HWY STRUCTURE/BRIDGE
11 LABORATORY
12 MAINTENANCE YARD
13 MOVING LANE CLOSURE
14 OFFICE BUILDING
15 PARKING LOT
16 REST AREA
17 RESIDENCE
18 SHOULDER CLOSURE
19 SHOP/WAREHOUSE
20 SIDEWALK
21 STAIRWAY
22 STREET/HWY LANE CLOSURE
23 TUNNEL/TUBE
24 COMMON CARRIER

F WEATHER/ENVIRONMENT
01 CLEAR
02 FOG
03 RAIN
04 SNOW
05 CLOUDY
06 WINDY
07 POOR LIGHTING
08 ADEQUATE LIGHTING
09 N/A

G. VISIBILITY
01 OVER 1/2 MILE
02 LESS THAN 1/2 MILE
03 LESS THAN 100 YARDS
04 N/A

H. ACTIVITY TYPE
01 BENDING
02 BURNING
03 CARRYING
04 CLIMBING
05 CRAWLING
06 DIVING
07 DRIVING
08 FLAGGING
09 GARDENING
10 HAMMERING
11 INSPECTING
12 JUMPING
13 LIFTING
14 ENTER/LEAVE VEHICLE
15 OFFICE WORK
16 PAINTING
17 PULLING
18 PUSHING
19 REACHING
20 RIDING
21 RUNNING
22 SHOVELING
23 SITTING
24 STANDING
25 STOOPING
26 USING BENCH TOOL
27 USING HAND TOOL
28 USING SHOP MACHINERY
29 WALKING
30 UNAUTHORIZED ACTIVITY
31 ASSIGNED DUTIES
32 ALTERCATION W/CO-WORKER
33 ALTERCATION W/SUPERVISOR
34 ADVERSE ACTION
35 USING PORTABLE POWER TOOL

I. ACCIDENT TYPE
01 ANIMAL/INSECT BITE/STING
02 CAUGHT IN MACHINERY
03 CAUGHT IN NON-MACHINERY
04 CHEMICAL EXPOSURE
05 CONTACT WITH ELECTRIC CURRENT
06 CONTACT WITH FIRE/FLAME
07 CONTACT WITH HOT OBJECT
08 CONTACT WITH POISONOUS PLANTS
09 CONTACT WITH SHARP OBJECT
10 EXPOSURE TO HIGH TEMPERATURE

I. ACCIDENT TYPE, CONTINUED
11 EXPOSURE TO LOW TEMPERATURE
12 EXPOSURE TO LOUD NOISE
13 EXPOSURE TO SUN
14 FALL FROM LADDER/STEPS
15 FALL FROM SPILLED LIQUID
16 FOREIGN OBJECT IN EYE
17 MOTOR VEHICLE COLLISION
18 RADIATION EXPOSURE
19 BODY MOTION/REPETITIVE
20 STRESS
21 STRUCK BY OBJECT
22 STRUCK BY MOTOR VEHICLE
23 TRIP/SLIP/FALL
24 EXPOSURE TO DUST
25 EXPOSURE TO GASES/FUMES
26 BODY MOTION/SINGLE EVENT
27 EXPOSURE TO BLOOD
28 EXPOSURE TO INFECTIOUS MATL
29 EXPOSURE TO VIRUS
30 EXPOSURE TO HAZARDOUS MATLS

J. PART OF BODY
01 ABDOMEN
02 ANKLE
03 ARM
04 BACK/LOWER
05 BACK/UPPER
06 BUTTOCK
07 CALF
08 CHEST
09 CIRCULATORY SYSTEM
10 EAR/HEARING
11 ELBOW
12 PSYCHOLOGICAL
13 EYES/VISION
14 FACE
15 FINGER
16 FOOT
17 FOREARM
18 GENITALS
19 GROINS
20 HAND
21 HEAD
22 HEART
23 HIP
24 INTERNAL ORGAN
25 KNEE/LOWER LEG
26 MOUTH/TEETH
27 NECK
28 NERVOUS SYSTEM
29 NOSE
30 RESPIRATORY SYSTEM
31 RIB

J. PART OF BODY, CONTINUED
32 SHOULDER
33 SPINE
34 THIGH
35 THROAT
36 TOE
37 WHOLE BODY
38 WRIST
39 MULTIPLE (SEE REVERSE)

K. NATURE OF INJURY
01 ABRASION
02 AMPUTATION
03 BITE/STING
04 BRUISE
05 BURN/SCALD
06 CANCER
07 CONCUSSION
08 CRUSH/PINCH
09 CUMUL. TRAUMA/PHYSICAL
10 CUT/PUNCTURE
11 DEATH BY ILLNESS
12 DEATH BY INJURY
13 DERMATITIS
14 DISLOCATION
15 EMOTIONAL STRESS/SPECIFIC INC.
16 BONE FRACTURE
17 HEARING LOSS
18 HERNIA
19 IRRITATION
20 NEUROLOGICAL
21 INFECTIOUS DISEASE
22 OVER EXERTION
23 SORENESS
24 PNEUMONIA
25 POISONING
26 SPRAIN
27 SPLINTER
28 STRAIN
29 TORN MUSCLE
30 STROKE
31 INHALATION
32 CUMUL. TRAUMA/PSYCHOLOGICAL
33 MULTIPLE (SEE REVERSE)
34 UNDETERMINED

S. OCCUPATION
01 ADM -ALL OFFICE WORK
02 LAB - LAB TESTING, FIELD AND LAB
03 SHP - MECHANICS, WELDERS, ETC.
04 CON -FIELD CONSTRUCTION
05 SUR - FIELD SURVEYS
06 FTR - FIELD TRAFFIC
07 TOL - TOLL SERVICES
08 FMT - FIELD MAINTENANCE
09 SPP - SPECIAL PROGRAM PEOPLE
10 CEM -CONTRACTORS EMPLOYEE**

☐ **CERTIFIED CORRECT; O.K. FOR DATA ENTRY**

_____
Safety Officer's signature

* ENTER THE UNIT NUMBER THE EMPLOYEE WAS CHARGED TO AT THE TIME OF THE ACCIDENT

** INCLUDED FOR TRACKING PURPOSES ONLY

FM 2238 M 95

MODIFIED WORK ASSIGNMENT AGREEMENT

Form PM-S-0004

STATE OF CALIFORNIA • DEPARTMENT OF TRANSPORTATION
MODIFIED WORK ASSIGNMENT AGREEMENT
PM-S-0004 (REV. 03/2000)

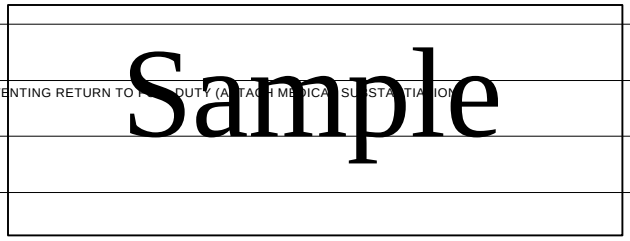
CONFIDENTIAL
This document contains personal information and pursuant to Civil Code 1798.21 it shall be kept confidential in order to protect against unauthorized disclosure.

☐ **WORK RELATED** INJURY/ILLNESS ☐ **NON-WORK RELATE D** INJURY/ILLNESS

EMPLOYEE NAME		DATE OF INJURY/ILLNESS
SUPERVISOR NAME	BUSINESS PHONE	WORK UNIT/COST CENTER

NATURE OF INJURY OR ILLNESS

DESCRIPTION OF LIMITATIONS PREVENTING RETURN TO FULL DUTY (ATTACH MEDICAL SUBSTANTIATION)



DESCRIPTION OF MODIFIED WORK ASSIGNMENT (DESCRIBE DUTIES TO BE PERFORMED)

NAME OF PHYSICIAN APPROVING RELEASE TO MODIFIED WORK

DATE MODIFIED WORK ASSIGNMENT TO BEGIN	DATE MODIFIED WORK ASSIGNMENT TO END

A MODIFIED WORK ASSIGNMENT IS **TEMPORARY** WORK INTENDED TO BE A TRANSITION PERIOD FOR RETURNING AN INJURED OR ILL EMPLOYEE TO HIS/HER POSITION WITHOUT LOSS OF PAY. **MAXIMUM DURATION OF A MODIFIED WORK ASSIGNMENT IS 90 CALENDAR DAYS**, UNLESS APPROVED FOR EXTENSION BY THE SUPERVISOR AND DISTRICT SAFETY OFFICER OR CASE MANAGER AS APPROPRIATE. EXTENSIONS MUST BE SUBSTANTIATED BY MEDICAL DOCUMENTATION. (ATTACH INFORMATION)

WE HAVE READ, FULLY UNDERSTAND, AND AGREE TO THE DUTIES DESCRIBED IN THE MODIFIED WORK ASSIGNMENT AGREEMENT.

EMPLOYEE'S SIGNATURE	SUPERVISOR'S SIGNATURE
DATE OF SIGNATURE	DATE OF SIGNATURE

DISTRIBUTION - MAKE COPIES AND DISTRIBUTE TO:

FOR WORK RELATED:

1. ORIGINAL TO DISTRICT SAFETY OFFICE OR WORKER'S COMPENSATION CASE MANAGEMENT UNIT
2. ONE COPY TO SUPERVISOR
3. ONE COPY TO EMPLOYEE

FOR NON-WORK RELATED:

1. ORIGINAL TO SUPERVISOR
2. ONE COPY TO EMPLOYEE

REPORTING INJURIES AND ILLNESSES

THIS SPACE AVAILABLE FOR NOTES: